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J SALAZAR DE SOUSA
 Department of Paediatrics,
 Hospital de Santa Maria,
 University of Lisbon,
 Portugal

Dr Dodge comments:

I am grateful for Professor Salazar de Sousa's comments. I had intended my paper to be provocative.

In my own practice, I follow the ESPGAN protocol and submit patients to three biopsies. However, this procedure is followed by only two-thirds of the members of ESPGAN¹ and I imagine that only a few nonspecialist general paediatricians in this country routinely perform a gluten challenge, followed by a biopsy. Moreover, the challenge procedure varies considerably from putting the patient on a free diet to daily administration of a prescribed large amount of gluten. The postchallenge biopsy is essential if a diagnosis of persistent gluten enteropathy is to be made. I want to encourage paediatricians who are daunted by the present protocol to give a gluten challenge to patients who have benefited clinically and, if known, histologically from a gluten-free diet.

Most of my patients in Cardiff seem to adhere very well to their dietary regimen, and it is exceptional to find one in whom the mucosa has not recovered when a second biopsy is performed. However, simply knowing that the mucosa is still abnormal would not ensure future patient compliance, and I believe that our good results can be attributed to the continuing advice and encouragement given to the parents by our dietician. The primary purpose of my paper was not to challenge the usefulness of the ESPGAN criteria (and I agree that we have nothing better at the moment), but to suggest that until we have a satisfactory definition of coeliac disease that is accepted both by physicians and paediatricians,² we could improve the clarity of our communications by using the terms 'gluten intolerance' and 'gluten enteropathy' to describe clinical symptoms and histological appearances. When Professor Salazar de Sousa tells me that a patient has

coeliac disease I understand him perfectly because we both use the same diagnostic criteria, but it seems more sensible to use accurate descriptive terminology when the investigative process is incomplete, or when the criteria are not agreed.

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J A DODGE
 Department of Child Health,
 Welsh National School of Medicine,
 Heath Park, Cardiff CF4 4XN

Dissolution of bilateral cystine calculi by penicillamine

Sir,

I read with interest the paper by Ruysch van Dugteren and Wiggelinkhuizen.¹ I have obtained similar results with alpha-mercaptopropionyl glycine. Cystine-lysine-ornithine-argininuria was diagnosed in two siblings—one with bilateral staghorn calculosis—by using high-tension electrophoresis. Calculi were dissolved by means of alpha-mercaptopropionyl glycine in the child with bilateral calculosis (Figs 1 and 2), while prevention, without presence of calculi, was achieved with the same drug in the other child. These results show that the drug is useful

Fig. 1 Patient aged 5 years: (x-rays of abdomen). Bilateral renal calculosis (arrows).